Dissenting Statement

Presented by
Orie Williams, Alaska Area Representative to the LNF Work Group
for Inclusion in the Work Group's Recommendation to the Director
February 12, 2001

The Alaska Representative to the Level of Need Funded (LNF) Work Group dissents from four of the actions of the LNF Work Group at its Denver meeting February 6-8, 2001.

1. Internal Cost Adjustment for Extremely Remote Locations in Alaska.

At the Denver meeting, the LNF Work Group rejected any adjustment to the internal cost factor to reflect the extraordinary cost of providing health services in the extraordinarily remote parts of Alaska that are inaccessible by Federal or State road.

Last year's LNF Work Group, which was responsible for developing recommendations for distribution of the FY 2000 Indian Health Care Improvement Fund (IHCIF),used a single internal price index for Alaska. This index was applied to the entire Area – Anchorage and all of the remote operating units that stretch from Barrow on the Bering Sea to the Aleutian Chain – a distance comparable to that from Michigan to San Francisco. The 138 percent adjustment was calculated by adding an arbitrary and unilateral adjustment to the 125 external raw price index for Anchorage, which was based on Medicare adjustments comparing the prices in Anchorage to the average lower 48 prices. No national data was available or used to adjust the Anchorage index to the more remote operating units.

The Alaska representative during last year's Work Group reluctantly accepted that decision for the FY 2000 distribution because the national experts advising the Work Group could not identify better data within the time frame necessary to distribute the ten million dollars available in the IHCIF. However, the Work Group conceded that data was needed to adjust the costs appropriately to the more remote operating units and a recommendation was made to look at this for the next fiscal year.

The Alaska Area participated in every consultation meeting held regarding the FY 2001 formula and presented extensive written justification for increasing the price index for the remote sites in Alaska above the budget neutral price index of 138. The Alaska tribes worked to develop specific proposals based on nationally accepted data for consideration by the Work Group at this meeting. Distribution based on the LNF Report can only be effective, if in each factor of the formula, all operating units are placed on a level playing field.

During the early stages of the Denver Work Group meeting in which the Work Group was assigned to develop recommendations for FY 2001 distribution, both experts with whom the Work Group consulted, Dr. David Hsia and Dr. Chris Hogan, confirmed in response to questions that Alaska presents a special case that must be dealt with specially in the cost factor. Dr. Hsia

said "Alaska is the exception – have to pay costs; there is no competition in really small areas." Dr. Hogan was asked about methodologies for recognizing the costs in remote areas of Alaska. He noted that he has looked for survey data and that there is none. He was asked about relying on Medicare Cost Reports, as proposed by Alaska at this meeting. He responded that it is "probably as good as anything," while acknowledging that some adjustment might be needed to address the way Medicare cost reports reflect relative inefficiencies of small hospitals, those less than 30 beds. In addition, Dr. Hsia noted the lack of competition in rural Alaska due to a non-desirable market reality.

The Work Group in Denver chose to ignore this expert advice and the information presented to the Work Group by the Alaska Area comparing Medicare Cost Report data for three remote sites to the same data for Anchorage. These cost reports reflect a weighted higher cost in remote sites (those not accessible by road) of 86 percent above Anchorage. After extensive debate and an emotional appeal from another representative to just look at how much money the Alaska programs have, the Work Group considered three proposals. The first would have increased the operating unit specific factor from FY 2000 by adding 15 percent (148 + 15) leaving Anchorage at 125, the raw price index for FY 2000, and adjusting the remote sites 15 points above the level in the FY 2000 allocation. That failed with a vote of 5 for and 9 against.

A second proposal was made after another Work Group member noted that the index from last year had to change. This proposal was to adjust the unilaterally established 138 internal cost index by 15 percent across all operating units. This failed for lack of a second. A third proposal was made to adjust the 138 internal cost index only for the remote sites making the remote sites 153% and Anchorage 125%. This failed with 6 for and 9 against.

Finally, a motion was made to leave the cost index exactly as it was last year, but to spread it to the operating units. That passed 12 for and 3 against. Both Co-Chairs and the Alaska Representative voted against it.

This decision to leave the Alaska internal cost adjustment the same as last year means that the real costs of providing health care in the most remote locations in which the Indian Health system operates are not reflected in the LNF formula. This undermines the reliability of the formula and utterly defeats the logic of using it as a distribution methodology. The raw dollar amount available to any particular operating unit is not an accurate, relative measure of cost. Cost has to be measured against objective, independent data. This is what the Work Group rejected. This is directly contrary to the commitment made by the Work Group in FY2000 to address the unique cost of providing health services in Alaska.

While rejecting an adjustment for the extraordinary costs in remote Alaska, the Work Group, based on less reliable data, protected health programs with low costs and positive health status values from the impact application of those numbers would have. Based on substantially less reliable data than that proposed by Alaska, a floor was established for the external price index so that the very low prices available in certain parts of one or two Areas would not be counted. Similarly, when the health status indices for the Oklahoma and California Areas seemed to reflect higher health status than "seemed right" the Work Group arbitrarily set the floor at that of the next healthiest Areas status. The effect of each of these adjustments was to raise the relative

level of need of these Areas, while the level of need for remote Alaskan operating units continue to reflect internal costs that are substantially below those that are documented by objective, externally verified data, the Medicare Cost Reports. Such decision-making invalidates the recommendations of the Work Group and of the LNF distribution process.

2. Health Status Index

The Work Group in Denver considered a variety of ways to improve the Health Status Index factor of the LNF formula in response to strong testimony during the public testimony. Five factors were considered: birth disparity index, life expectancy disparity, health problems and diseases, population over age 54, and poverty. On a divided vote, the Work Group adopted a formula in which the birth disparity index equals 15 percent; health problems and diseases equals 75 percent and population over age 54 equals 10 percent.

When Dr. Hsia, who was in attendance throughout much of the meeting, was asked to comment on the various factors being considered and their relative weight, he noted that given the diseases factored into the "health problems and diseases" index that it is functionally duplicative of the "population over age 54" factor since the diseases listed are those that most often affect older people with the one exception of a small part of the calculation devoted to injuries. He also noted that the birth disparities index is a good proxy for the costs of births and for the continuing costs of monitoring and caring for children and parents who experience the long term affects of the conditions that contributed to the disproportionately high number of low and high birth weight babies.

Despite the fact that 43 percent of American Indians and Alaska Natives are under age 20, one of the highest percentages in the United States, 85 percent of this factor is weighted to addressing the problems of the elderly. This is shortsighted and contrary to the advice from Dr. Hsia. Dr. Hsia noted that given the youthfulness of the population, the problems of young people "are not trivial," or put, more affirmatively, are more significant than in the general population.

At one point in the discussion, the Work Group had weighted the formula in a more balanced way. This discussion was diverted by a comment from the audience about Medicaid funding for births. This misses the point entirely. This factor of the formula is intended to reflect the costs associated with health status. The availability of alternate resources is addressed elsewhere in the formula.

The Alaska representative is convinced that the imbalance in the health status factor away from recognition of the extraordinary health problems faced by our children and their parents will ultimately devalue the formula by understating the costs associated with their needs. Although the demand for treatment of cancer, diabetes and heart problems is critical and should be recognized, we should strive for balance of these concerns with others. The health status index as adopted does not achieve this critical balance.

3. Allocation to Lowest 60 Percent or Tiered.

The Work Group chose to allocate funds only to those operating units with LNF scores lower

than 60 percent. In doing so, the Work Group rejected the testimony of tribal leaders advocating for some distribution to all operating units that must function with fewer resources than needed to meet their obligations. Alaska supports the tiered approach and dissents from the decision to limit funding. Allocations are inherently divisive. Tribes cannot afford to be divided on matters as critical as funding for health services. Funding all operating units, albeit at increasingly low levels, helps maintain support throughout Indian country for increasing the resources. It also does not diminish the funding for those who are lowest. In fact, the tiered approach actually devotes a higher percentage to those with the lowest level of funding. All operating units with an LNF index less than full funding are in need. Even a small amount can help.

4. Recurring or Non-Recurring.

The Alaska Area would like to be able to support a recurring distribution. Predictability of funding is important to all health programs whether operated by tribes or IHS. We cannot, however, when substantive parts of the formula are calculated to continue the inequities described above. Only when the formula is driven by fact and a commitment to sound science can we support it being used to justify recurring distributions. Until then, while we wait for the promise to be kept that data will be considered, we feel compelled to object to the decision to make the FY 2001 distribution recurring.

Conclusion.

For the reasons discussed above, I must dissent from the recommendations of the Work Group. I do this with great reluctance. The Alaska Area prides itself on its efforts to work together to assure the best interest of all the tribes – small and large. We have always believed that what is best for one tribe must be balanced to be best for all Tribes. This applies to the Tribes in the lower-48, not just to those in Alaska. When tribes are pitted one against the other, we all lose.

Allocation formulas are inherently difficult. I understand that. They can only work when everyone is willing to put their self-interest aside and adhere to a set of principled decisions that ensure everyone is treated the same and that all legitimate interests are fairly balanced. Formulas that are outcome-driven ultimately fail because the stated justification never really corresponds to the outcome-driven bottom line decision-making. I very reluctantly conclude that the Work Group succumbed to the temptation to engage in the latter at the expense of achieving true equity.

At least one tribal leader member of the Work Group talked openly about being jealous of the technical expertise and consultants Alaska could bring to the meeting, and of the funding Alaska has been able to get, and of the Alaska Native Medical Center, and of the position of the senior Senator from Alaska. I understand that jealousy. I confront my jealousy everyday – jealousy of locations where every site can be reached by road, jealousy of sites that are near medical schools, jealousy of sites that don't contend with epidemics of RSV every winter, jealousy of operating units where illnesses are not exacerbated by the lack of the most basic sanitation, jealousy of places that can provide dialysis to their beneficiaries without requiring them to move to Anchorage hundreds of miles away from their home in a village. I try to control that jealousy and stay focused on doing what I can with what we have – no matter how inadequate it is to the task.

Those who are jealous of Alaska are taking only the most superficial look. They are looking at dollars without considering cost; they are looking at the Alaska Native Medical Center in Anchorage and not at the decrepit and unsafe facilities in Barrow, St. Paul, and Metlakatla. They are not considering the principles of the Level of Need Funded report that is based on finding a way to compare across widely varying environments. Their approach is like suggesting that one Mexican peso is the equivalent of one United States dollar. They both have a "one," but by all objective measures it still takes 9.70 pesos to buy the equivalent of what one dollar will buy. Failure to take into account the real documented costs of providing services in remote regions of Alaska is just as unreliable and inconsistent with the LNF formula as treating as equal the currencies of different countries.

I can only support the decisions of the Work Group if its work is based on the best scientific and most objective information, which did not occur at this Work Group meeting. Leaving the internal cost adjustment for remote sites in Alaska the same as last year required ignoring the advice of the Work Group consultants, Dr. Hsia and Dr. Hogan, and rejecting objective data based on Medicare Cost reports that demonstrate the higher costs outside Anchorage. I cannot support or endorse such decisions. I, therefore, dissent from the decisions of the Work Group.